CANCER RESOURCE CENTER
OF THE FINGER LAKES
612 W. State St. * Ithaca, NY 14850 * (607) 277-0960 * www.crcfl.net

PEER SUPPORT REQUEST

Date: _____

Name: _____

Street Address: _____

City, State, Zip: _____

Email: _____

Home Phone_____ Cell Phone:_____

Best time to call_____ Ok to leave message? Y or N

MATCHING INFORMATION

Year of Diagnosis: _____ Diagnosis (specific type and origin of cancer including stage)

_____

Treatments (surgery, chemo, radiation):

_____

_____

Age: _____

Children at Home? Y or N Ages_____

CMC Patient? Y or N (If no, where are you receiving treatment?_____)

Please share your reasons for wanting to participate in the peer support program.
Please describe any significant concerns or questions you would like to speak to a peer about.
_____

I understand that information I share with my peer mentor will be kept confidential
and I agree to keep all information that my peer mentor shares with me confidential.

Signature _____ Date_____